

have not been established, but all reports are unanimous in suggesting that follow-up audiologic evaluations of infants not meeting the screening criteria are mandatory in the first three to four months following discharge. Interpretation to the parents of the consequences of a failure to evoke the auditory brain-stem response in their newborn must be made with caution so they do not assume "deafness" on the basis of such a screening.

Finally, certain types of hearing loss escape identification at birth using this procedure. Therefore, infants whose history or physical findings place them at risk for hearing loss should be examined during the first few months of life regardless of the findings of an auditory brain-stem evoked response at birth.

The integrity of an infant's peripheral auditory system can be evaluated systematically in the first few months of life. Infants at risk for hearing loss should be referred to practitioners experienced in evaluating this disorder. There is no justification for "waiting and watching" the development of an infant until the age of two to three years before referring the child for audiologic evaluation including auditory brain-stem evoked response testing.

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## Skin Tests or RAST—Current Concepts

CORRECTLY DONE skin tests (such as serial dilution titration or its equivalent) and the radioallergosorbent test (RAST) both detect IgE antibody with a high degree of accuracy and reproducibility, and both supply information of a quasi-quantitative type. The results of both types of tests generally correlate well with a patient's history and with the signs and symptoms of specific allergens tested. However, the radioallergosorbent test is generally conceded to be somewhat less sensitive than skin tests.

Both RAST and serial dilution titration can be used as the basis for efficient and effective immunotherapy. When RAST values are relied on, a skin test should always be done, using the indicated initial dilution of allergen, before a patient is given a desensitization series.

Skin tests are recognized as superior to RAST in testing for sensitivity to penicillin and Hymenoptera allergens. Skin test results are usually available in about 20 minutes whereas RAST results generally take about two days.

RAST is preferable when generalized dermatologic problems exist or when dermatographia is a problem. The economic factor usually favors the use of skin testing over RAST.

In summary, both serial dilution titration skin testing or its equivalent and RAST are reliable methods for assaying IgE-mediated allergens. Skin testing is generally accepted as more sensitive and economical at present. RAST is highly accurate and the method continues to be refined. It is reliable and most helpful when dermatologic problems or other specific situations make skin testing undesirable. When using either method, it is essential that testing be closely monitored

by an allergist who is qualified to judge whether the test results correlate well with a careful history and observable signs and symptoms.

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## New Approaches to Treatment in Glottic, Subglottic and Tracheal Stenosis

LARYNGOTRACHEAL STENOSIS has long been a difficult management problem for which there is no simple solution. Although it may be congenital, most of the cases we see are acquired. This is due to the increased use of prolonged intubation for mechanical ventilation and the increased incidence of vehicular trauma to the anterior neck.

Endoscopic repair of laryngotracheal stenosis decreases morbidity and mortality. There are patients who simply will not tolerate resection of a tracheal stricture when the risk of morbidity may be up to 20%. In addition, the voice is better after endoscopic procedures than after laryngofissure and the possibility of a later open operation is not jeopardized by initial endoscopic attempts at repair. Dilatation in our experience does not work well unless the scar is so thin that it is almost a mucosa-on-mucosa stenosis.

In a group of 19 patients seen at the University of California, San Francisco, 8 of 9 (89%) cases of posterior glottic stenosis and 9 of 10 (90%) cases of subglottic or tracheal stenosis were successfully treated. These patients were relieved of their shortness of breath and the cannula was removed if they had had a tracheotomy. This was accomplished in most patients with one or two procedures. We were not successful in cases of posterior stenosis if the cricoarytenoid joints were frozen nor in cases of subglottic or tracheal stenosis if the lesion was much longer than 1 cm. The endoscopic technique has been used effectively in a patient with a tracheal lesion that was only 2 cm above the carina.

Glottic stenosis is either anterior or posterior or it can be total. Endoscopic treatment of anterior glottic stenosis is best done with laser and endoscopic Teflon Keel placement. Posterior glottic stenosis is usually due to prolonged intubation and, when the scar completely immobilizes the arytenoids, it can cause apparent bilateral vocal cord paralysis. If a scar band has a mucosa-lined sinus behind it (usually only seen by direct laryngoscopy) it can often be handled by simple laser division. If a scar completely obliterates the posterior commissure and is subglottic or tracheal, then a micro-trapdoor mucosal flap is created to cover the endoscopically removed scar tissue. This is done by excavating the scar starting at the superior aspect of the stenosis in one quadrant. The preserved overlying mucosa is then incised along the lateral aspects, creating an inferiorly based flap. No suturing of the